Division of Health Care Facilities

PRINTED: 06/11/2
FORM APPRO

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TN1601 | A. BUILDING _____ B. WING _____ | 06/09/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| UNITED REGIONAL MEDICAL CENTER NURSII | 1001 MCARTHUR DRIVE MANCHESTER, TN 37355 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLET DATE |
|---|---|---|---|---|
| N 000 | Initial Comments<br><br>During the annual Licensure survey and investigation of complaints #23009 and #24809, conducted on June 7-9, 2010, at United Regional Medical Center Nursing Home, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes. | N 000 | | |

Vision of Health Care Facilities

Holly Hopkins

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: 6/24/10

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